Claims Reporting Guide

Version 2.0
January 1, 2007

Definition of Terms:

October 1, 2004
Revised: February 1, 2005
Revised: November 7, 2006

Aged Claims Inventory - Total number of claims by age based on the Julian date the claim is received.

Adjudicated Claims– Claims which have been received and processed by the Contractor which result in payment or denial of payment.

Clean Claim - A claim that may be processed without obtaining additional information from the provider of service or from a third party; but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

Claim Forms - The paper claim forms for submitting claims to the Contractor. The claim forms are: HCFA (or CMS) 1500 for professional claims, the UB 92 (or UB 04) for institutional claims, the ADA for dental claims.

Claims Inventory – The total quantity of claims on hand/in house at the end of the reporting period. All claims received that the Contractor is responsible for processing. The inventory will include those few pharmacy claims received to be processed by the Contractors.

Claims Receipts - Total claims received in the month being reported.
Contractor – Health Plan or Program Contractor

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Date of Processing (DOP) – Date claim processed by Contractor

Date of Receipt (DOR) – Date claim received by Contractor

Electronic Data Interchange (EDI) - The claims that are submitted to the Contractor electronically through a clearinghouse or the Contractor's web site.

EDI Auto-Processing - Claims that are received via EDI and adjudicated in the claims system without review or intervention.

EDI Claim Formats - Claims that are submitted in an X-12 – 837 format. The formats are: 837P for professional claims, 837D for dental claims, 837I for institutional claims.

EFT – Electronic Funds Transfer

End of Month (EOM) - Last day of reporting period
Incurred But Not Reported (IBNR) - The liability for services rendered for which claims have not been received.

Membership - The total number of members as of the first day of the month after the month for which the data is being reported per AHCCCS website:

ACUTE
http://www.azahcccs.gov/Statistics/Enrollment/Acute/Enrollment.asp
ALTCS
http://www.azahcccs.gov/Statistics/Enrollment/ALTCS/2006/altcenrl102006.asp
For example; For October report use November enrollment data and for November report use December enrollment data.

Pended Claims –Claim(s) that is/are manually or electronically suspended awaiting review and/or instruction for adjudication.

Processing – Processing includes all the steps that a Contractor puts claims through from receipt up to and including putting the remittance advice in the mail or final execution of the EFT. The time to process is calculated in calendar days from the date of receipt of the claim to the date of the check, the date of the remittance advice for denied claims, or the date the Electronic Funds Transfer (EFT) occurs. The date on the check is the SAME date that the check is put in the mail.

Received But Unpaid Claims (RBUC) - Received but unpaid claims divided by the average daily medical expenses for the period, net of sub-capitation expense.

Total Medical Claims Liability - The sum of IBNR and RBUC.

General Instructions:

1. Each dashboard is dedicated to one line of business (ALTCS or Acute). The dashboard(s), along with all attachments, should be sent to the Contractor's Acute Operations and Compliance Officer (ACO) or ALTCS Financial Compliance Officer (FCO) via email. If hard copies need to be sent please send to the appropriate ACO or FCO at:

   AHCCCS Division of Health Care Management (DHCM)
   701 E. Jefferson, MD 6100
   Phoenix, Arizona 85034

2. A separate Claims Dashboard must be submitted for each of the following claim form types:

   - UB92 or 837I
   - CMS1500 or 837P and, Dental Claim Form or 837D combined
   - All claim form types combined.

3. If the Contractor has sub-contracted with a Third Party Administrator (TPA) to process the claims that the Contractor would normally process, a dashboard, for each claim form type above, for the TPA must be submitted. Pharmacy Benefit Management (PBM) claims are the exception, and should not be reported in either of the Contractor's dashboards or a separate dashboard.

4. The following items are to be reported as of the last day of the month (see claims dashboards Attachments A, B and C):
   Claims Inventory (C1 through C6)
   Days Work on Hand (E1)
   Percentage of Pended Claims (F)
   Number of Pended Claims (G)
   Number of Medical Review Pended Claims (I)

   All other data elements should be based on the monthly total.

5. The Contractor should highlight each area that is out of compliance with contracted standards, areas where there is a 5% increase from the previous report in number of denied and/or pended claims, areas where claims receipts have decreased by greater than 5%, areas where average time to process claims has increased by more than 5 days, areas where total claims processed has decreased by 5%.

6. If you should have any questions regarding the dashboard or requirements, please contact your ACO or FCO.

Spreadsheet Instructions:

(Spreadsheet is Attachment A, B and C)

A. Membership – As of the first day of the month, following the month for which data is reported, per AHCCCS website:

   ACUTE
   http://www.azahcccs.gov/Statistics/Enrollment/Acute/Enrollment.asp
   ALTCS
   http://www.azahcccs.gov/Statistics/Enrollment/ALTCS/2006/altcenrl102006.asp

B1. Total claims received in the month.

B2. % of total claims received in the month that were paper claims.

B3. % of total claims received in the month that were in EDI format.

B4. % of claims paid via EFT. $\frac{\text{Total Number of claims paid}}{\text{Total number of claims paid via EFT}}$

C1 through C4 - The number of claims in each age band.

C5 – The total number of (new day) claims in the inventory.

C6 – total number of claims not considered in C5 (i.e. special project claims).

D. Average day's receipts: $\frac{\text{Total receipts for the month}}{\text{Number of workdays in the month}}$

E1. (Attachment A) Institutional/Hospital (UB92, UB 04, 837I):

$$\frac{\text{Total institutional claims inventory}}{\text{Average daily institutional claims processed}}$$

E1. (Attachment B) Professional (HCFA 1500, CMS 1500, 837P) and Dental (ADA, 837D):

$$\frac{\text{Total professional claims inventory + Total dental claims inventory}}{\text{Average daily (professional + dental) claims processed}}$$

E1. (Attachment C) Total Claims inventory:

$$\frac{\text{Total Claims inventory}}{\text{Average daily total claims processed}}$$

F. % of pended claims not paid in 30 days:

$$\frac{\text{Total claims pended greater than 30 days}}{\text{Total claims inventory}}$$

G. Total Number of claims pended.

G1. Number of claims pended longer than 60 days.

H. Total number claims pended for medical review that are 61+ days old.

I. Average age of claims pended for medical review.

J1. % of claims denied: $\frac{\text{Total number of claims denied in the month}}{\text{Total number of claims processed in the month}}$

J2. Total dollars denied in the month.

J3. Total number of claims denied.

K. Average time to process all claims:

$$\frac{\text{Sum of the ages of each processed claim (including denials)}}{\text{Total number of claims processed (including denials) in the month}}$$

L. Total claims processed as of the last day of the reporting period.

L1. % of total claims processed that were processed within the contracted deadline. This reporting measure is for those Contractors that have contracts with submitters that specify processing of clean claims in time frames different than AHCCCS contract stated 30 days. Contractors that have a combination of standard (30 day processing requirements) and non-standard agreements are to complete L2 for your standard agreements and L1 for the non-standard agreements.

L2. Of the claims not included in L1, the % of total claims processed that were processed within 30 days of receipt.

L3. Of all claims (L1 and L2), the % of total claims processed that were processed in 60 days of receipt.

M. EDI claims auto-processing rate:

$$\frac{\text{Total number of EDI claims auto-processed during period reported}}{\text{Total number of EDI claims processed during period reported}}$$

N. Incurred but not received claims (IBNR).

O. Received but unpaid claims (RBUCS).

P. Estimated total medical claims liability: IBNR + RBUCS.

Q. Amount of interest paid in the reporting period (If none enter “0”).

To be reported on the Total Claims Dashboard Template Only.

R. Report % of claims paid correctly, for the reporting period, as determined from internal audit procedures.

S. Total amount of advances paid to providers in the reporting period (If none enter “0”).

Footer: Along with written explanation of highlighted areas from number 5 above, include the following information with each report. If any of the following information is not applicable please be sure to indicate.

- **List top 5 reasons for claim denials** and how many claims denied during the reporting period for each denial reason.
- **List the 5 providers with the greatest number of claims denials** include how many claims are denied for each provider.
- **List all providers for which Contractor is working on a special claims processing or claims review project.** Include the following information:
  - Reason for project
  - How many claims are affected
  - Stratify claim count by age of claim (0-30 days, 31-60 days etc) using each of the following
    - Stratify by date of service
    - Stratify by start of project date